EXHIBIT 1

Michael Catabay 06/10/2006

1. Have you ever heard Larry Headington use profanity on the work room floor?

2. Did Larry Headington put a note on Katherine Williams back?

I DIDN'T SEE

3. Did you ever see Larry Headington shoot rubber bands at Katherine Williams?

Yes, not just at her he does it to everyone

4. Have you ever heard Larry Headington speak with malice about Katherine Williams?

No

5. Were you playing around with Larry Headington while you were training Katherine Williams on route 19

No but we probably were laughing but we were not playing around

6. Have you ever seen Larry Headington show any aggression toward Katherine Williams?

Interview conducted by
Darcella Kibodeaux
SCS
On 06/10/2006

Exhibit 26
p. 1 of 2

Mike C 6-10-06 1007 #12

1. was Profanity used by Larry or you? No.

2. did Larry put a Note on her Back. I think so

3. Did you ever See Larry Shoot Rubber bands at Katherine? Yes, Not just her Everyone.

4) Have you ever heard Larry Speak with ~~but heard~~ Malice Katherine. No

5) Were you playing around w Larry while you were training Katherine. on K19. No, we probable were laughing but not playing around.

6) Have you ever Seen Larry Show any aggression toward Katherine. No

Exhibit 20
p. 2 of 2

EXHIBIT 2

EMPLOYEE'S CLAIM FOR PERSONAL PROPERTY

Type or write legibly in ink. Submit in triplicate to your supervisor within [illegible] days [illegible] or 90 days (if you are a non-bargaining employee) from the date that damage occurred.

Part One – This Page Completed by Employee

Name of Claimant: Katherine Williams	SSN: 512-90-1508 — Job Title of Claimant: Rural Carrier Assoc.
Claimant's Home Address: 445 Fordham Cir. Vallejo, CA 94589-1867	Claimant's Work Address/Work Phone Number: Fairfield Post Office Annex 325 Merganser Dr. Suisun, CA 94585
Date Loss/Damage Occurred: 3/28/06 11/14/06	Total Amount of Claim: $ 145.90 plus $25.00 to set stone

Article(s) for Which Claim is Made

(Include paid receipt or other evidence showing purchase date and original price of lost or damaged article. If repairable, include an estimate for repair. If not repairable include a statement from a tailor, dry cleaner, etc., to substantiate. If claim is for eyeglasses, state exactly what part(s) are broken; include an itemized receipt for the REPLACEMENT of damaged part(s). Replacement must be of the same quality as the damaged part(s).)

See attached copies of purchases and cost of repair for Mother's ring
a) mother's ring DOL 3/28/06
b) 1/4 Buttercup earring DOL 11/14/06

Description of Loss or Damage

(Give place, extent of damage, [illegible] circumstances of accident involving [illegible] damage. State salvage value.)

a) On 3/28/06 Darcie shoved my hand with an advo into the metal case and chipped my Mothers' ring and injuring my 3rd finger
b) I was in Unemployment meeting when my purse unexpectedly fell on my leg causing me to jump hitting my ear losing my 1/4 butter cup earring my present mental state was brought on from work conditions assaults and harassment

Insurance Coverage/Recovery Attempt

Homeowner Insurance [illegible] Yes [illegible] No

Comprehensive [illegible] [illegible]

Has Claim been made with Insurance Company? Yes No

If yes, [illegible]

Name & Address of Insurance Company [illegible]

Amount of Deductible
$

If damage/loss resulted [illegible] has an attempt been made to recover from that party?
X Yes No [illegible]

I certify that the damage [illegible] was not caused in whole or in part by any negligence [illegible] or his agent or employee. All articles listed [illegible] form have [illegible] property. No previous claim has been made to the government for the property for which this claim is made [illegible]. This claim does not duplicate [illegible] under the Workmen's Compensation Program.

If [illegible]

I make the foregoing claim with full knowledge [illegible] wilfully making a false claim [illegible] a maximum fine of $[illegible] or imprisonment [illegible]

I hereby assign to the United States [illegible] claim accepted by me all my right, title, and interest [illegible] may have against any insurer or other party arising out of the damage or destruction of the property described on this form and will [illegible] furnish such [illegible] as may be required [illegible] United States [illegible] such claim.

PRIVACY ACT [illegible] authorized by 39 USC 1001 & 2008. It will be used [illegible] [illegible] to a labor organization as required by the NLRA [illegible] gating an EEO complaint [illegible] a legal proceeding to which the Postal Service is a party [illegible] of this form [illegible] this information [illegible] reimbursement [illegible]

Date of Claim: 11/28/06	Claimant's Signature: Katherine Williams

November 15, 2007

Katherine Williams
445 Fordham Cir
Vallejo, CA 94589-1867
(707) 643-2423
Employee Claim # F00R-4F-E06276213

United States Postal Service
Labor Relations
Pacific Area Office
390 Main St. #234
San Francisco, CA 94199-4401

Area Labor Relations Specialist
Dear Ms. Ross:

I'm not satisfied with the decision that my claim for $145.90 for damages of my Mother's ring and the lost earring was not approved and I'm appealing this decision because first of all the postal service should not have had an employee who would put their hand on another and cause injury and damage to someone else property. Darcie Kibodeaux shouldn't have been in a leadership position supervising anyone. She shoved my hand into the metal casing on March 28, 2006. I was subjected to harassment and assault while I worked in that dungeon without supervision or monitoring from the postmaster or the manager. She has lied throughout this whole investigation and submitted fraudulent document and had me fired while under doctor's care. Oh no! I don't agree with that at all. I didn't damage the ring myself; the ring was damaged by one of your employees who seem to have a mental problem, defiantly an integrity problem. After all the months of harassment and assaults I was subjected to and put on medicine to bring me back to my right mind my ring started looking funny, it was never bumped until the acts of the supervisor who was over us (your responsibility) that's when I took it to the shop and was told that the stone was chipped. You are responsible for any damages that is caused be another employee especially something that was intentionally done. If my child damage something I as the parent/adult is responsible for their actions. It was filed as soon as I was told of the damage. I wouldn't need to file a claim if this person hadn't put her hand on me and shoved it into the metal casing.

Sincerely,
Katherine Williams

cc: Union Representative
Postmaster
Manager, Human Resourses
Kurtis K. Buttars
Johnny Aguilera
Bay Valley District

LINCOLN JEWELERS
915 Texas Street
Fairfield, CA 94533
(707) 425-3062

LINCOLN LOAN CO.
350 Georgia Street
Vallejo, CA 94590
(707) 642-6775

(OPEN END) REVOLVING CREDIT ACCOUNT
Account # 3249

90 days
Ca. DL

SALES CONTRACT/ SECURITY AGREEMENT

to be delivered upon payment of $ ____ Due ____

NOTICE TO THE BUYER: Do not sign this security agreement before you read it or if it contains any blank spaces. You are entitled to a completely filled in copy of this agreement. This agreement may not be cancelled. If this merchandise is lost or stolen, or damaged or destroyed, you must continue to pay this agreement in full.

A. Lincoln Jewelers ("we", "us", "ours") sells and you (Name) Katherine Williams 94589
(Address) 745 Fordham Circle Dr (Phone) 643 2423

hereby buys and accepts, subject to the terms and conditions below, the merchandise described as follows:

	DESCRIPTION	CODE NUMBER	PRICE
200	3 Stone Mothers Ring with 3 Dias Charge 2 STONE		$ 350 —
300	to Match and (Blue TOPAZ LONDON) Ladys Tennis Bracelet with Champagne Diamonds		$ 150 —
150	1/2 Figure Bracelet Lds Solid Bangle 5347		$ 75 —
300	SALES TAX		$ 150 —
	TOTAL CASH PRICE		= $ 534 — 778 47
	LESS: DOWN PAYMENT	$	
	LESS: TRADE IN (CODE #'S	) - $	=
	TOTAL DOWN PAYMENT & TRADE IN		— $
	UNPAID BALANCE		= $
	CURRENT BALANCE OF EXISTING ACCOUNT (IF APPLICABLE)		+ $
	NEW BALANCE OF ACCOUNT		= $

(1) **Definitions.** In this agreement, the words your and yours mean the customer or A. Lincoln Jewelers signing this agreement. The words we, us and ours mean A. Lincoln Jewelers.

(2) **Monthly Statement.** If you have a balance on your account we will send you a monthly statement. It will show separately your purchases, the **Finance Charge**, the minimum payments due, the date the payment is due, and the payments you made during the month as well as other important information.

(3) **Minimum Payment.** The minimum payment will be $ 200.00 due on 5-6-05 and $ 100.00 due on or before 6-6-05 and each 6th of month thereafter $ 100.00 until the entire balance of your account has been paid in full.

(4) **Paying More Than the Minimum.** You may at any time pay more than the minimum amount due – or even the full amount without a penalty. Larger payments during the billing cycle will result in a smaller "balance subject to **Finance Charge**," as described in (5) below.

(5) **Finance Charges.** Unless you paid the "balance subject to **Finance Charges**" shown on your monthly statement in full by its payment due date, a **Finance Charge** will be added to your account toward this way:
(1) We start with the balance of your account at the beginning of the billing period.
(2) During the period we subtract payments and credits.
(3) We then take the balance of your account at the end of the billing period (called "balance subject to **Finance Charge**") and multiply this amount by the following periodic rate:
(13.92% ANNUAL PERCENTAGE RATE)
(4) No **Finance Charge** will be applied to any purchases of merchandise during the billing period in which the purchases were made.

(6) **Additional Purchase.** A. Lincoln Jewelers is permitted to add your subsequent purchases to this agreement, and to increase the maximum payment and add Finance Charges provided for in this agreement.

(7) **Security.** To protect A. Lincoln Jewelers, you give us what is known as a security interest in the merchandise which you purchase from A. Lincoln Jewelers. This means that ownership of the merchandise you are now buying will remain with A. Lincoln Jewelers until it is fully paid for.

(8) **Removal of Merchandise.** You agree to notify A. Lincoln Jeweler within 10 days, in writing, of any change of your name, employment, residence or any place to which the merchandise secured by this agreement is moved.

(9) **Defaults.** You will be in default if:
(1) you do not pay a minimum payment on time, or
(2) you sell, pawn, or borrow against the merchandise, or
(3) bankruptcy or insolvency proceedings are instituted by or against you.
If you are in default, A. Lincoln Jewelers can, by law, demand immediate payment of your entire account. A. Lincoln Jewelers also has the right to repossess, sell and apply the proceeds to your account, retain all payment made, and to recover reasonable attorneys fees and costs incurred by A. Lincoln Jewelers.

(10) **Permission.** If you are in default, you agree that A. Lincoln Jewelers has permission to communicate information concerning your account to your employer or any other business or personal references.

REMINDER NOTICE TO BUYER (YOU)

(A) Do not sign this security agreement before you read it or if it contains any blank spaces.

(B) You are entitled to a completely filled in copy of this agreement.

(C) All sales are final! No cash refunds! Exchanges gladly with receipt. Ten day exchange period. No exceptions!

(D) We have the right to change contract terms.

IF YOU SIGN THIS AGREEMENT, YOU HAVE READ AND UNDERSTAND IT COMPLETELY.

* highlight is purchase of Mothers ring

ID #

Buyer X Katherine William

Name(s) & Relationship(s) of other person(s)
KATHERINE WILLIAMS

Sales Consultant

JEWELRY REPAIR

TO REORDER CALL 1-800-243-6144
www.starstruckinc.com

LINCOLN LOAN CO.

350 Georgia Street
Vallejo, CA 94590
(707) 642-6719

Repair Hours: 9:00am - 5:30pm Mon - Sat

DATE RECEIVED	DATE PROMISED	35346
ESTIMATED COST	**DECLARED VALUE**	**RECEIVED BY**
$	$ 60 plus 25.00	

NAME: Tiffany Williams

ADDRESS:

CITY: ST: ZIP:

WORK PHONE: HOME PHONE:

DESCRIPTION

Ring Gold Marie

INSTRUCTIONS

plus $ 25.00 to set stone

I have received and inspected the item(s) listed on this envelope and the work performed is to my satisfaction and the item(s) are in good condition. Items were received: ____ with ____ without original claim receipt.

Customer's Signature: Tiffany Williams

Delivery Date: By: Paid: $

*Stone in ring chipped when Darcie shoved my hand into metal casing cost of repair $ 60.00

LINCOLN JEWELERS
911 Texas Street
Fairfield, CA 94533
(707) 42[illegible]

LINCOLN LOAN CO.
350 Georgia Street
Vallejo, CA [illegible]
(707) 64[illegible]

OPEN END REVOLVING CHECK ACCOUNT 3249
Account # [illegible]

Ted de Cay Cash

SALES CONTRACT/ SECURITY AGREEMENT

NOTICE TO THE BUYER Do not sign this agreement before you have read it or if it contains any blank spaces. You are entitled to a completely filled in copy of this agreement. This agreement may not be [illegible] if the goods are [illegible]. You must continue to pay [illegible] in full.

A Lincoln Jewelers/Loan hereby sells and (Name) Kathy Williams
(Address) 4445 Fordham Circle Oak 94589
(Phone) 643-2423

hereby buys and accepts, subject to the terms and conditions below, the merchandise described as follows:

DESCRIPTION	CODE NUMBER	PRICE
Buttercup D/Dia Earrings		$ 80—
		$
		$
	5.90	$ 5.90
SALES TAX		$
TOTAL CASH PRICE		$ 85.90
LESS: DOWN PAYMENT $		
LESS: TRADE IN (CODE #'S) + $		
TOTAL DOWN PAYMENT & TRADE IN		$
UNPAID BALANCE		$
CURRENT BALANCE OF EXISTING ACCOUNT (IF APPLICABLE)		$
NEW BALANCE OF ACCOUNT		$

(1) **Definitions.** In this agreement, the words your and yours mean the customer of A. Lincoln Jewelers signing this agreement. The words we, us and ours mean A. Lincoln Jewelers.

(2) **Monthly Statement.** If you have a balance on your account we will send you a monthly statement. It will show separately your purchases, the **Finance Charge**, the minimum payments due, the date the payment is due, and the payments you made during the month as well as other important information.

(5) **Finance Charges.** Unless you paid the "balance subject to **Finance Charges**" shown on your monthly statement in full by its payment due date, a **Finance Charge** will be added to your account figured this way.
(1) We start with the balance of your account at the beginning of the billing period.
(2) During the period we subtract payments and credits.

(3) **Minimum Payment.** The minimum payment will be $ ____ due on ____ and $ ____ due on or before ____ and each ____ of month thereafter $ ____ until the entire balance of your account has been paid in full.

(4) **Paying More Than the Minimum.** You may at any time pay more than the minimum amount due – or even the full amount without a penalty. Larger payments during the billing cycle will result in a smaller "balance subject to **Finance Charge**," as described in (5) below.

(3) We then take the balance of your account at the end of the billing period (called "balance subject to **Finance Charge**") and multiply this amount by the following periodic rate (13.92% ANNUAL PERCENTAGE RATE).
(4) No **Finance Charge** will be applied to any purchases of merchandise during the billing period in which the purchases were made.

(6) **Additional Purchases.** A [illegible] add your [illegible] purchases to the [illegible] Finance Charges [illegible]

(7) **Security.** To protect A. Lincoln Jewelers, you [illegible] is known as a security interest in the merchandise which you purchase [illegible] A. Lincoln Jewelers [illegible] that ownership of the merchandise you are now buying will remain with A. Lincoln [illegible]

(8) **Removal of Merchandise.** You agree to notify A. Lincoln Jewelers within 10 days in writing of any change of your name, employment, residence or any place [illegible] the merchandise secured by this agreement is moved.

(9) **Defaults.** You will be in default if:
(1) you do not pay a minimum payment on time; or
(2) you sell, pawn, or [illegible] against the merchandise; or
(3) bankruptcy or insolvency proceedings are instituted by or against you.

If you are in default, A. Lincoln Jewelers can by law demand immediate payment of your entire account. A. Lincoln Jewelers also has the right to repossess, sell and apply the proceeds to your account, retain a payment made, and to recover reasonable attorneys fees and costs incurred by A. Lincoln Jewelers.

(10) **Permission.** If you are in default, you agree that A. Lincoln Jewelers has permission to communicate information concerning your account to your employer or other business or personal references.

REMINDER NOTICE TO BUYER (YOU)

(A) Do not sign this security agreement before you read it or if it contains any blank spaces.
(B) You are entitled to a completely filled in copy of this agreement.
(C) All sales are final. No cash refunds. Exchanges [illegible] ten day [illegible] period. No [illegible]
(D) We have the right to [illegible]

IF YOU SIGN THIS AGREEMENT YOU HAVE READ AND UNDERSTAND IT COMPLETELY

✗ Because of my present mental state when my Purse unexpectedly fell forward hitting my leg I jumped and lost my earring.

Buyer ✗ Katherine Williams

Kathy Williams

[illegible] SALES CONTRACT

EXHIBIT 3

Bay-Valley Performance Cluster
Injury Compensation Specialist
UNITED STATES
POSTAL SERVICE

July 12, 2006

KATHERINE WILLIAMS
445 FORDHAM CIR
VALLEJO CA 94589-1867

This letter is in regard to your job-related injury of **03/17/06.**

We are sorry to hear you have suffered an injury and sincerely hope this note finds you well on your way to recovery.

We would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA). FECA benefits include but are not limited to the following:

- Initial choice of physician (chiropractor care is usually not covered)
- Payment of injury related medical expenses
- Up to 45 calendar days of continuation of pay (COP) on CA-1 traumatic injury
- Compensation for wage loss after the 45 calendar day COP period expires
- Compensation for permanent impairment of specified member of the body
- Vocational rehabilitation services
- Death benefits

Penalty For False Statement:

Any employee, supervisor, or representative who knowingly makes a false statement with respect to a claim under FECA may be subject to a fine of not more than $10,000.00 or 5 years in prison, or both (20 CFR 10.23).

For wage loss after the 45-calendar day COP period, you will need to file a **CA-7. If you want to buy back personal leave, the CA-7 must be filed within one year of the injury. IF YOU USE YOUR PERSONAL SICK LEAVE OR ANNUAL LEAVE YOU MAY ONLY BUY BACK THAT LEAVE USED DURING THE ADJUDICATION PROCESS OF YOUR CLAIM. Once OWCP has given a decision on your claim, you may not buy back any personal leave from that date forward (ELM 512.923).** If you have not returned to work you may however be entitled to LWOP which is paid directly by OWCP.

While FECA provides for the above benefits, it also places certain responsibilities on the injured employee. Specifically, it is your responsibility to:

- Complete and submit the employee's portion of the CA-1 or CA-2

1675 7Th Stree Rm. 416
Oakland, CA 94615-9446
Ph: (510)874-8288
Fax:(510)8748281

Manager Post Office Operations
Ed Kimble 1675 7th St #311
1510 874-8252 Oakland, CA 94615-9992

Bay-Valley Performance Cluster
Injury Compensation Specialist

- Arrange for the submission of prima facie (i.e., true, valid, and sufficient at first impression) medical evidence of an injury to your supervisor, or injury compensation office. Failure to provide medical evidence may result in termination of all benefits.
- **Limited duty will be offered! You must notify your physician and request them to specify the limitations and restrictions that apply. Immediately turn in the CA-17 to your supervisor or the Injury Compensation Office.**
- **You are obligated to return the limited duty job offer or risk losing your benefits.**
- **You must immediately report any outside employment if you are unable to return to a limited duty position with the Postal Service.**

In assigning limited duty we will follow the provisions of the Employee and Labor Relations Manual 546.142(a) so as to minimize any adverse disruptive effect on you.

Injury compensation personnel are available to provide guidance or assistance on matters related to your injury. If you have any questions you may call the following number: (510) 874-8286.

Sincerely,

Pauline Melchor
IC Specialist

cc: File

1675 7Th Stree Rm. 416
Oakland, CA 94615-9446
Ph: (510)874-8288
Fax:(510)8748281

# of Occupational Disease
laim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

ployee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
nploying Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Number: 572-90-1508
3. Date of birth: Mo. 5 Day 12 Yr. 59
4. Sex: F
5. Home telephone: (707) 643-2423
6. Grade as of date of last exposure: Level 5 Step Y
7. Employee's home mailing address (include city, state, and ZIP Code)
445 Fordham Cir.
Vallejo, CA 94589-1867
8. Dependents
☐ Wife, Husband
☐ Children under 18 years
☐ Other
9. Employee's occupation: Rural Route Carrier Assoc.
10. Location (address) where you worked when disease or illness occurred (include city, state, and ZIP Code)
Fairfield Annex Post Office
325 Merganser Dr.
Suisun, CA 94585
11. Date you first became aware of disease or illness: Mo. 3 Day 17 Yr. 06
12. Date you first realized the disease or illness was caused or aggravated by your employment: Mo. 3 Day 17 Yr. 06
13. Explain the relationship to your employment, and why you came to this realization
I started working on 3/17/06 I was shot with rubber bands by a co-worker, he put a sticky On my back I contime working trying to ignore him finally his behavior and actions started escalating showing aggression while passing my work area he almost knocked me down with his hamper. I became concerned and afraid for my personal safety I've ne done anything to receive this treatment from anyone at that Post Office.
14. Nature of disease or illness: Stree/mental anguish my blood pressure has been fluctuating since I started workin which was in control before 3/17/06 after being harassed and discriminated suffered mentally, experiencing anger
15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay. I was new was hoping after co-workers got to know me their actions towards me would change and get better working relationship only got worst escalating into hostile work environment almost assultive, be singled out by my supervisor she treated me differently from other workers.
16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay.
see attached no other form received enclosed is copy of State Disability form and patient health information
17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.
see attached no other form received enclosed is copy of State Disability form and patient health information
18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Katherine Williams Date 7/1/06

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Supervisor's Report of Occupational Disease. Please complete information requested below

Employee's Report

ncy name and address of reporting office (include city
airfield Rural Row
600 Kentucky St
Fairfield CA. 94533

Bay – Valley Performance Cluster
Injury Compensation Office
1675 7th Street, Rm – 416
Oakland, CA 94615-9446

OWCP Agency Code 543200
OSHA Site Code 94585

20. Employee's duty station (Street address and ZIP Code)
325 Merganser Dr. Suisun City CA ZIP Code 94585

21. Regular work hours From: 8 00 ☒ a.m. ☐ p.m. To: 4:30 ☐ a.m. ☐ p.m.

22. Regular work schedule ☐ Sun. ☒ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. (worked monday only this week)

23. Name and address of physician first providing medical care (include city, state, ZIP code)
975 Sereno Drive
Vallejo CA. 94589

24. First date medical care received Mo. 6 Day 13 Yr. 06

25. Do medical reports show employee is disabled for work? ☒ Yes ☐ No

26. Date employee first reported condition to supervisor Mo. N/A Day Yr. 6/7/06

27. Date and hour employee stopped work Mo. N/A Day 6 Yr. 13/06 Time : ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. N/A Day Yr. 6/13/06 Time : ☐ a.m. ☐ p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. N/A Day Yr.

30. Date returned to work Mo. N/A Day Yr. Time separated ☐ a.m. ☐ p.m. 6/15/06
Did Not pass probation - poor performance

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other (Specify)
N/A

33. Was injury caused by third party? ☐ Yes ☒ No If "No," go to Item 35.

34. Name and address of third party (include city, state, and ZIP Code)

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception: See Attached Letter Challenged Claim - Based on fact of injury

Darcella S Kibodeaux
Name of Supervisor (Type or print)

Signature of Supervisor

7-7-06
Date

204 B
Supervisor's Title

707-425-8248
Office phone

Form CA-2
Rev. Jan. 1997

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Num: 572-90-15
3. Date of birth: Mo. 5 Day 12 Yr. 41
4. Sex: Male ☐ Female ☒
5. Home telephone: 707 643-2423
6. Grade as of date of injury: Level 5 St
7. Employee's home mailing address (include city, state, and ZIP code): 445 Fordham Cir. Vallejo, CA 94589
8. Dependents: Wife, Husband; Children under; Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fairfield Annex Post Office 325 Merganser Dr. Suisun, CA 94
10. Date injury occurred: Mo. 3 Day 18 Yr. 06 Time: 10:00 ☒ a.m. ☐ p.m.
11. Date of this notice: Mo. 11 Day 9 Yr. 06
12. Employee's occupation: Rural Route Carrier Assoc
13. Cause of injury (Describe what happened and why): While casing my route #19 Larry shot me on the left leg 4 x's rubber bands leaving welps on my leg
14. Nature of injury (Identify both the injury and the part of the body e.g. fracture of left leg): welps on left leg

a. Occupation code:
b. Type code:
c. Sour
OWCP Use - NOI Code:

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☐ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital for any other person, institution, corporation, or government agency to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs for that's official business purposes. This authorization also permits any duly authorized representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf: Katherine Williams Date: 11/9/06

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury):

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Form C

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury; however, to avoid possible interruption of pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)

(2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

(5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent facts must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

(1) The employing agency receives medical information from the attending physician to the effect that disability has terminated:

(2) The OWCP advises that pay should be terminated; or

(3) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 days period expires.

An employee may use sick or annual leave rather than LWOP while disabled. The employee may repurchase leave used for approved periods. Form CA-7b, available from the personnel office, should be studied BEFORE a decision is made to use leave.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974, (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)
Katherine Williams

Which occurred on (Mo., Day, Yr.)
3-18-06

At (Location)
Fairfield Annex

Signature of Official Superior

Title
Supervisor

Date (Mo., Day, Yr.)
11-16-2006

* Claim form for being shot with rubber bands but Darcie didn't turn in denying that it ever occurred

Form CA-1
Rev. Jan. 1997

eral Employee's Notice of aumatic Injury and Claim for ontinuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Number: 572-90-1508
3. Date of birth: Mo. 5 Day 12 Yr. 59
4. Sex: ☐ Male ☒ Female
5. Home telephone: (707) 643-2423
6. Grade as of date of injury: Level 5 Step E
7. Employee's home mailing address (include city, state, and ZIP code): 445 Fordham Cir. Vallejo, CA 94589-1867
8. Dependents: ☐ Wife, Husband ☐ Children under 18 ye. ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fairfield Annex Post Office 325 Merganser Dr. Suisun, CA 94585
10. Date injury occurred: Mo. 3 Day 28 Yr. 06 — Time: 11 :00 ☒ a.m. ☐ p.m.
11. Date of this notice: Mo. 11 Day 4 Yr. 06
12. Employee's job title: Rural Route Carrier Associate
13. Cause of injury (Describe what happened and why): I was casing rt #19 Margie came barrelling into my casing causing me t stumble backwards ceasing pain to rt. knee "see sheet"
14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg): Pain and discomfort in rt knee when I walked or moved it.

a. Occupation code
b. Type code
c. Source co
OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Katherine Williams **Date** 11/4/06

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

eral Employee's Notice of aumatic Injury and Claim for ontinuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Number: 572-90-150
3. Date of birth: Mo. 5 Day 12 Yr. 54
4. Sex: ☐ Male ☒ Female
5. Home telephone: (707) 643-2423
6. Grade as of date of injury: Level 5 Step E
7. Employee's home mailing address (include city, state, and ZIP code): 445 Fordham Cir. Vallejo, CA 94589-1867
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 ye
   - ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fairfield Annex Post Office 325 Merganser Dr. Suisun, CA 94585
10. Date injury occurred: Mo. 3 Day 28 Yr. 06
    Time: 11:00 ☒ a.m. ☐ p.m.
11. Date of this notice: Mo. 11 Day 4 Yr. 06
12. Employee's job title: Rural Route Carrier Associa
13. Cause of injury (Describe what happened and why): I was casing rt.#19 when Darcie came into my casing shoving my hand with an adro in it into the metal Case
14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg): Pain in rt third fingers Knockle when I bend it

a. Occupation code
b. Type code
c. Source co
OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Katherine Williams **Date** 11/4/06

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

11/4/06

On 6/8/06 I was in my cusing Pt # 19 standing behind my big orange hamper Larry waited until I got my hamper and aggressively bumped into my hamper almost knocking me down. His behavior and actions had escalated into almost assult of my person. I did nothing to Larry, Dance or Mange to warrent this harassment.

I reported incidents before no one told me until 11/3/06 that I need to fill out forms for each injury. This is why it is just getting done

Injury Compensation Office
Bay-Valley Performance Cluster
UNITED STATES
POSTAL SERVICE

February 12, 2007

KATHERINE WILLIAMS
445 FORDHAM CIR
VALLEJO CA 94589

This letter is in regard to your job-related injury of **03/18/06.**
We would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA). FECA benefits include but are not limited to the following:

- Initial choice of physician (chiropractor care is usually not covered)
- Payment of injury related medical expenses
- Up to 45 calendar days of continuation of pay (COP) on CA-1 traumatic injury
- Compensation for wage loss after the 45 calendar day COP period expires
- Compensation for permanent impairment of specified member of the body
- Vocational rehabilitation services
- Death benefits

Penalty For False Statement:

Any employee, supervisor, or representative who knowingly makes a false statement with respect to a claim under FECA may be subject to a fine of not more than $10,000.00 or 5 years in prison, or both (20 CFR 10.23).

For wage loss after the 45-calendar day COP period, you will need to file a **CA-7. If you want to buy back personal leave, the CA-7 must be filed within one year of the injury. IF YOU USE YOUR PERSONAL SICK LEAVE OR ANNUAL LEAVE YOU MAY ONLY BUY BACK THAT LEAVE USED DURING THE ADJUDICATION PROCESS OF YOUR CLAIM. Once OWCP has given a decision on your claim, you may not buy back any personal leave from that date forward (ELM 512.923).** If you have not returned to work you may however be entitled to LWOP which is paid directly by OWCP.

While FECA provides for the above benefits, it also places certain responsibilities on the injured employee. Specifically, it is your responsibility to:

- Complete and submit the employee's portion of the CA-1 or CA-2
- Arrange for the submission of prima facie (i.e., true, valid, and sufficient at first impression) medical evidence of an injury to your supervisor, or injury

1675 7th Street
Oakland Ca 94615-9446
Ph: (510) 874-8288
Fax: (510)874-8281

compensation office. Failure to provide medical evidence may result in termination of all benefits.

- **Limited duty will be offered! You must notify your physician and request them to specify the limitations and restrictions that apply. Immediately turn in the CA-17 to your supervisor or the Injury Compensation Office.**
- **You are obligated to return the limited duty job offer or risk losing your benefits.**
- **You must immediately report any outside employment if you are unable to return to a limited duty position with the Postal Service.**

In assigning limited duty we will follow the provisions of the Employee and Labor Relations Manual 546.142(a) so as to minimize any adverse disruptive effect on you.

Injury compensation personnel are available to provide guidance or assistance on matters related to your injury. If you have any questions you may call the following number: (510) 874-8286.

Sincerely,

Pauline Melchor

Pauline Melchor
IC Specialist

cc: File

1675 7th Street
Oakland Ca 94615-9446
Ph: (510) 874-8288
Fax: (510)874-8281

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Number: 572-90-1508
3. Date of birth: Mo. 5 Day 12 Yr. 59
4. Sex: ☐ Male ☑ Female
5. Home telephone: (707) 643-2423
6. Grade as of date of injury: Level 5 Step 8 Y
7. Employee's home mailing address (include city, state, and ZIP code): 445 Fordham Cir. Vallejo, CA 94589
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fairfield Annex Post Office 325 Merganser Dr. Suisun, CA 94585
10. Date injury occurred: Mo. 3 Day 18 Yr. 06
    Time: 10 :00 ☑ a.m. ☐ p.m.
11. Date of this notice: Mo. 2 Day 2 Yr. 07
12. Employee's job title: Rural Route Carrier Assoc.
13. Cause of injury (Describe what happened and why): I was casing route #19 Larry was casing route #20 he came around and shot me with 4 rubber bands leaving welps on left leg calf
14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg): Welps on left leg calf. (4)

a. Occupation code
b. Type code
c. Source code
OWCP Use Nature code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☑ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Katherine Williams **Date** 2/2/07

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

INJCOMPWITFED 6pm 12:42

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

ficial Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include
Fairfield

Bay – Valley Performance Cluster
Injury Compensation Office
1675 7th Street, Rm – 416
Oakland, CA 94615-9446

OWCP Agency Code 543200

OSHA Site Code 94533

18. Employee's duty station (Street address and ZIP Code) ZIP Code

19. Employee's retirement coverage ☒ CSRS ☐ FERS ☐ Other, (identify)
325 Merganser Dr. Suisun City, CA 94585

20. Regular work hours From: 8:00 ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of injury	23. Date notice received	24. Date stopped work	25. Date pay stopped	26 Date 45 day period began	27. Date returned to work
Mo. Day Yr. 2 8 06	Mo. Day Yr. 2 6 07	Mo. Day Yr. DID NOT STOP Time: ☐ a.m. ☐ p.m.	Mo. Day Yr. DID NOT STOP	Mo. Day Yr. 3 19 06	Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ No (If "No," go to item 32.)

31. Name and address of third party (include city, state, and ZIP code)

32. Name and address of physician first providing medical care (include city, state, ZIP code)

33. First date medical care received Mo. Day Yr. 3 18 06

34. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☐ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work
$ 17.51 Per HR

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:
Challenged based on facts of injury

Pauline Melcho
Name of Supervisor (Type or print)

Injury Compensation Spec.
Signature of Supervisor

Date 2/6/07

Supervisor's Title

Office phone (510) 874-8288

39. Filing instructions
☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
☐ No lost time, medical expense incurred or expected: forward this form to OWCP
☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
☐ First Aid Injury

Injury Compensation Office
Bay-Valley Performance Cluster
UNITED STATES
POSTAL SERVICE

February 12, 2007

KATHERINE WILLIAMS
445 FORDHAM CIR
VALLEJO CA 94589

This letter is in regard to your job-related injury of **03/28/06.**
We would like to take this opportunity to advise you of some of the benefits and responsibilities that are accorded by the Federal Employees' Compensation Act (FECA). FECA benefits include but are not limited to the following:

- Initial choice of physician (chiropractor care is usually not covered)
- Payment of injury related medical expenses
- Up to 45 calendar days of continuation of pay (COP) on CA-1 traumatic injury
- Compensation for wage loss after the 45 calendar day COP period expires
- Compensation for permanent impairment of specified member of the body
- Vocational rehabilitation services
- Death benefits

Penalty For False Statement:

Any employee, supervisor, or representative who knowingly makes a false statement with respect to a claim under FECA may be subject to a fine of not more than $10,000.00 or 5 years in prison, or both (20 CFR 10.23).

For wage loss after the 45-calendar day COP period, you will need to file a **CA-7. If you want to buy back personal leave, the CA-7 must be filed within one year of the injury. IF YOU USE YOUR PERSONAL SICK LEAVE OR ANNUAL LEAVE YOU MAY ONLY BUY BACK THAT LEAVE USED DURING THE ADJUDICATION PROCESS OF YOUR CLAIM. Once OWCP has given a decision on your claim, you may not buy back any personal leave from that date forward (ELM 512.923).** If you have not returned to work you may however be entitled to LWOP which is paid directly by OWCP.

While FECA provides for the above benefits, it also places certain responsibilities on the injured employee. Specifically, it is your responsibility to:

- Complete and submit the employee's portion of the CA-1 or CA-2
- Arrange for the submission of prima facie (i.e., true, valid, and sufficient at first impression) medical evidence of an injury to your supervisor, or injury

1675 7th Street
Oakland Ca 94615-9446
Ph: (510) 874-8288
Fax: (510)874-8281

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Number: 572-90-1508
3. Date of birth: Mo. 5 Day 12 Yr. 59
4. Sex: ☐ Male ☒ Female
5. Home telephone: (707) 643-2423
6. Grade as of date of injury: Level 5 Step 5
7. Employee's home mailing address (include city, state, and ZIP code): 445 Fordham Cir. Vallejo, CA 94589-1867
8. Dependents: ☐ Wife, Husband ☐ Children under 18 ye ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fairfield Annex Post Office 325 Merganser Dr. Suisun, CA 94585
10. Date injury occurred: Mo. 3 Day 28 Yr. 06 Time: 11 :00 ☒ a.m. ☐ p.m.
11. Date of this notice: Mo. 2 Day 2 Yr. 07
12. Employee's job title: Rural Route Carrier Assoc.
13. Cause of injury (Describe what happened and why): Margie bumped into me causing me to stumble backwards pain rt. kn
Darcie shoved my hand into metal casing injured rt. 3rd finger
a. Occupation code: 23250700
14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg): Pain in rt. knee when I walked or moved it.
Pain in 3rd rt. finger knockle when I bend it.
b. Type code: 999 c. Source co: 9999
OWCP Use - NOI Code: 211

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Katherine Williams **Date** 2/2/07

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Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

INJCOMP'07FEB 6PM12:42

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Number: 572-90-1508
3. Date of birth: Mo. 5 Day 12 Yr. 59
4. Sex: ☐ Male ☒ Female
5. Home telephone: (707) 643-2423
6. Grade as of date of injury: Level 5 Step
7. Employee's home mailing address (include city, state, and ZIP code): 445 Fordham Cir. Vallejo, CA 94589-1867
8. Dependents: ☐ Wife, Husband ☐ Children under 18 ye ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fairfield Annex Post Office 325 Merganser Dr. Suisun, CA 94585
10. Date injury occurred: Mo. 3 Day 28 Yr. 06
Time: 11 :00 ☒ a.m. ☐ p.m.
11. Date of this notice: Mo. 2 Day 2 Yr. 07
12. Employee's job title: Rural Route Carrier Assoc.
13. Cause of injury (Describe what happened and why): Margie bumped into me causing me to stumble backwards pain rt. kn
Darcie shoved my hand into metal casing injured rt. 3rd finger
14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg): Pain in rt. knee when I walked or moved it.
Pain in 3rd rt. finger knockle when I bend it.
a. Occupation code: 23230 XX
b. Type code: 999
c. Source co: 9999
OWCP Use - NOI Code:

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Katherine Williams **Date** 2/2/07

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

INJCOMP'07FEB 6PM12:42

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): Williams, Katherine
2. Social Security Number: 572-90-1508
3. Date of birth: Mo. 5 Day 12 Yr. 59
4. Sex: ☐ Male ☒ Female
5. Home telephone: (707) 643-2423
6. Grade as of date of injury: Level 5 Step 5
7. Employee's home mailing address (include city, state, and ZIP code): 445 Fordham Cir. Vallejo, CA 94589
8. Dependents: ☐ Wife, Husband ☐ Children under 18 yea ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): Fairfield Annex Post Office 325 Merganser Dr. Suisun, CA 94585
10. Date injury occurred: Mo. 6 Day 8 Yr. 06 Time: 11 :30 ☒ a.m. ☐ p.m.
11. Date of this notice: Mo. 2 Day 2 Yr. 07
12. Employee's job title: Rural Route Carrier Assoc.
13. Cause of injury (Describe what happened and why): I was standing behind my orange hamper Larry passed my work area aggressively bumping his orang hamper into mines
14. Nature of injury (Identify both the injury and the part of the body, e.g., fracture of left leg): Knee hurt

a. Occupation code: 232507 X Y
b. Type code: 160
c. Source code: 8310
OWCP Use NOI Code: 291

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf Katherine Williams **Date** 2/2/07

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

INJCOMP 07FEB 6PM12:43

Name of witness | Signature of witness | Date signed

Address | City | State | ZIP Code

Official Supervisor's Report: Please complete information requested below:

Supervisor's Report

17. Agency name and address of reporting office (include c
Fairfield
600 Kentucky St.

Bay – Valley Performance Cluster
Injury Compensation Office
1675 7th Street, Rm – 416
Oakland, CA 94615-9446

OWCP Agency Code 54320
OSHA Site Code 94733

18. Employee's duty station (Street address and ZIP Code)
Fairfield CA
ZIP Code 94533

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other, (identify)
325 Merganser Drive Suisun City, CA 94585

20. Regular work hours From: : ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sa

22. Date of injury	23. Date notice received	24. Date stopped work	25. Date pay stopped	26 Date 45-day period began	27. Date returned to work
Mo. Day Yr. 6 8 06	Mo. Day Yr. 2 6 07	Mo. Day Yr. DID NOT STOP Time ☐ a.m. ☐ p.m.	Mo. Day Yr. DID NOT	Mo. Day Yr. 6 9 06	Mo. Day Yr. Time : ☐ a.m. ☐ p.m.

28. Was employee injured in performance of duty? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☑ Yes ☐ No (If "No," go to item 32.)

31. Name and address of third party (include city, state, and ZIP code)

32. Name and address of physician first providing medical care (include city, state, ZIP code)

33. First date medical care received Mo. Day Yr. 7 3 06

34. Do medical reports show employee is disabled for work? ☐ Yes ☐ N

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☐ Yes ☐ No (If "No," explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work $ 17.51 Per HR

Signature and Title of Supervisor (See instructions)

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception: Challenged based on fact of injury

Pauline Nelder
Name of Supervisor (Type or print)

Injury Compensation Spec.
Signature of Supervisor

Date 2-6-07

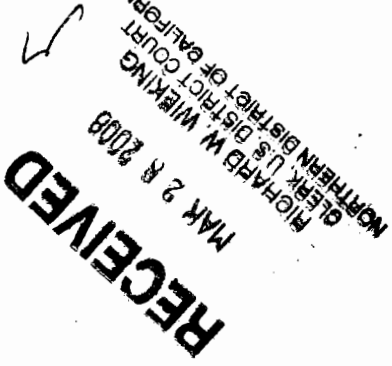
Supervisor's Title

Office phone (510) 874-8288

39. Filing instructions
☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
☐ No lost time, medical expense incurred or expected: forward this form to OWCP
☑ Lost time covered by leave, LWOP, or COP: forward this form to OWCP
☐ First Aid Injury

Catherine Williams
145 Fordham Cir.
Vallejo, CA 94589-1867
C 08-00026WHA

FIRST CLASS



United States District Court
450 Golden Gate Ave Courtroom #9
San Francisco, CA 94102-3495